FOR OHF USE

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039834

Facility Name: JACKSON CORPORATION d/b/a JACKSON SQUARE NURSING CENTER

Address: 5130 WEST JACKSON BOULEVARD (Number) CHICAGO (City) 60644 (Zip Code)

County: COOK

Telephone Number: (773) 921-8000 **Fax #** (773) 921-3980

IDPA ID Number: 36-3961688001

Date of Initial License for Current Owners: 7/1/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)
(Print Name and Title) RICHARD S. SGARLATA, C.P.A
(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE NURSING CENTER # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	234	Skilled (SNF)	234	85,644	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	234	TOTALS	234	85,644	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	69,506	1,860	5,726	77,092	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	69,506	1,860	5,726	77,092	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.01%

D. How many bed-hold days during this year were paid by Public Aid? 2,991 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 7/1/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/1/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 66 and days of care provided 4,068

Medicare Intermediary ADMINASTARFEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSO # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	228,302	47,923	9,690	285,915		285,915		285,915			1
2	Food Purchase		311,615		311,615	(19,830)	291,785	(75)	291,710			2
3	Housekeeping		41,494	330,000	371,494		371,494		371,494			3
4	Laundry		23,676		23,676		23,676		23,676			4
5	Heat and Other Utilities			243,206	243,206		243,206	874	244,080			5
6	Maintenance	90,096	56,586	141,227	287,909		287,909	(1,165)	286,744			6
7	Other (specify):*							(21)	(21)			7
8	**TOTAL General Services**	318,398	481,294	724,123	1,523,815	(19,830)	1,503,985	(387)	1,503,598			8
	B. Health Care and Programs											
9	Medical Director			21,600	21,600		21,600		21,600			9
10	Nursing and Medical Records	2,462,101	134,934	17,412	2,614,447		2,614,447	(8,180)	2,606,267			10
10a	Therapy	84,039		12,782	96,821		96,821		96,821			10a
11	Activities	74,386	14,545	2,936	91,867		91,867		91,867			11
12	Social Services	59,159		2,162	61,321		61,321		61,321			12
13	Nurse Aide Training	19,851		1,900	21,751		21,751		21,751			13
14	Program Transportation			4,938	4,938		4,938	1,942	6,880			14
15	Other (specify):*							197	197			15
16	**TOTAL Health Care and Programs**	2,699,536	149,479	63,730	2,912,745		2,912,745	(6,041)	2,906,704			16
	C. General Administration											
17	Administrative	95,232		662,077	757,309		757,309	(522,222)	235,087			17
18	Directors Fees											18
19	Professional Services			106,695	106,695	(3,500)	103,195	2,182	105,377			19
20	Dues, Fees, Subscriptions & Promotions			85,564	85,564		85,564	(38,135)	47,429			20
21	Clerical & General Office Expenses	177,789	43,571	69,896	291,256		291,256	114,567	405,823			21
22	Employee Benefits & Payroll Taxes			506,601	506,601	19,830	526,431		526,431			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,423	7,423		7,423	1,108	8,531			24
25	Other Admin. Staff Transportation			1,442	1,442		1,442	535	1,977			25
26	Insurance-Prop.Liab.Malpractice			129,899	129,899		129,899	264	130,163			26
27	Other (specify):*							29,289	29,289			27
28	**TOTAL General Administration**	273,021	43,571	1,569,597	1,886,189	16,330	1,902,519	(412,412)	1,490,107			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,290,955	674,344	2,357,450	6,322,749	(3,500)	6,319,249	(418,840)	5,900,409			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

JACKSON CORPORATION d/b/a JACKSON SQUARE NURSING CENTER
0039834
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	19,830	
2	FOOD		19,830

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	3,500	
19	PROFESSIONAL FEES		3,500

To reclass cost of appealing real estate taxes

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE NU#0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			100,757	100,757		100,757	105,860	206,617			30
31	Amortization of Pre-Op. & Org.			7,212	7,212		7,212	(7,212)				31
32	Interest			94,178	94,178		94,178	863,169	957,347			32
33	Real Estate Taxes			322,850	322,850	3,500	326,350		326,350			33
34	Rent-Facility & Grounds			1,389,201	1,389,201		1,389,201	(1,378,856)	10,345			34
35	Rent-Equipment & Vehicles			3,858	3,858		3,858	6,742	10,600			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,918,056	1,918,056	3,500	1,921,556	(410,297)	1,511,259			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	11,186	285,918	142,431	439,535		439,535	34	439,569			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			128,466	128,466		128,466		128,466			42
43	Other (specify):*	39,496			39,496		39,496	(39,496)				43
44	**TOTAL Special Cost Centers**	50,682	285,918	270,897	607,497		607,497	(39,462)	568,035			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,341,637	960,262	4,546,403	8,848,302		8,848,302	(868,599)	7,979,703			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	100,397	30		9
10	Interest and Other Investment Income	(1,450)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(75)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,122)	21		18
19	Entertainment				19
20	Contributions	(14,500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(36,000)	21		24
25	Fund Raising, Advertising and Promotional	(25,556)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,961)	20		28
29	Other-Attach Schedule	(59,581)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (43,848)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(824,751)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (824,751)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (868,599)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

JACKSON CORPORATION d/b/a JACKSON SQUARE NURSING CENTER

ID# 0039834

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	Veterans Expense	(9,248)	10	2
3	MARKETING SALARIES	(39,496)	43	3
4	CAPITALIZED PAINTING AND DECORATING	(2,601)	6	4
5	AMORT. EXPENSE	(7,212)	31	5
6	ILCTC COPE DUES	(377)	20	6
7	PRIOR YEAR LEGAL FEES.	(647)	19	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(59,581)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE N # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(75)											(75)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			874									874	5
6	Maintenance	(2,601)		1,436									(1,165)	6
7	Other (specify):*			(21)									(21)	7
8	**TOTAL General Services**	(2,676)		2,289									(387)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(9,248)		1,068									(8,180)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation			1,942									1,942	14
15	Other (specify):*			197									197	15
16	**TOTAL Health Care and Programs**	(9,248)		3,207									(6,041)	16
	C. General Administration													
17	Administrative			(600,458)	111,999	(33,763)							(522,222)	17
18	Directors Fees													18
19	Professional Services	(647)		2,156		673							2,182	19
20	Fees, Subscriptions & Promotions	(42,394)		3,090		1,169							(38,135)	20
21	Clerical & General Office Expenses	(41,122)		147,384		8,305							114,567	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			1,063		45							1,108	24
25	Other Admin. Staff Transportation			535									535	25
26	Insurance-Prop.Liab.Malpractice			264									264	26
27	Other (specify):*			21,552	2,893	4,844							29,289	27
28	**TOTAL General Administration**	(84,163)		(424,414)	114,892	(18,727)							(412,412)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(96,087)		(418,918)	114,892	(18,727)							(418,840)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE N # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	100,397		5,463									105,860	30
31	Amortization of Pre-Op. & Org.	(7,212)											(7,212)	31
32	Interest	(1,450)	867,178	(2,559)									863,169	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(1,389,201)	10,345									(1,378,856)	34
35	Rent-Equipment & Vehicles			6,742									6,742	35
36	Other (specify):*													36
37	**TOTAL Ownership**	91,735	(522,023)	19,991									(410,297)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers			34									34	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(39,496)											(39,496)	43
44	**TOTAL Special Cost Centers**	(39,496)		34									(39,462)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(43,848)	(522,023)	(398,893)	114,892	(18,727)							(868,599)	45

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE NURSING CENTI# 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 1,389,201	JACKSON ASSOCIATES		$	$ (1,389,201)	1
2	V	32	INTEREST EXPENSE		JACKSON ASSOCIATES		867,178	867,178	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,389,201			$ 867,178	$ * (522,023)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE NURSING CENTER # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	NUCARE SERVICES CORP.	100.00%	$ 874	$ 874	15
16	V	6	REPAIRS AND MAINT.		NUCARE SERVICES CORP.	100.00%	1,436	1,436	16
17	V	7	EMPLOYEE BEN. GEN. SERV.		NUCARE SERVICES CORP.	100.00%	(21)	(21)	17
18	V	10	NURSING ADMIN. COMP.		NUCARE SERVICES CORP.	100.00%	1,068	1,068	18
19	V	14	PROGRAM TRANSPORTATION		NUCARE SERVICES CORP.	100.00%	1,942	1,942	19
20	V	15	HEALTHCARE BENEFITS		NUCARE SERVICES CORP.	100.00%	197	197	20
21	V	19	PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	2,156	2,156	21
22	V	20	FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.	100.00%	3,090	3,090	22
23	V	21	CLERICAL & GENERAL		NUCARE SERVICES CORP.	100.00%	147,384	147,384	23
24	V	24	SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	1,063	1,063	24
25	V	25	ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.	100.00%	535	535	25
26	V	26	INSURANCE		NUCARE SERVICES CORP.	100.00%	264	264	26
27	V	27	EMPLOYEE BEN. GEN. ADMIN.		NUCARE SERVICES CORP.	100.00%	21,552	21,552	27
28	V	30	DEPRECIATION		NUCARE SERVICES CORP.	100.00%	5,463	5,463	28
29	V	32	INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	(2,559)	(2,559)	29
30	V	34	BUILDING RENT		NUCARE SERVICES CORP.	100.00%	10,345	10,345	30
31	V	35	EQUIPMENT RENTAL		NUCARE SERVICES CORP.	100.00%	6,742	6,742	31
32	V	39	ANCILLARY		NUCARE SERVICES CORP.	100.00%	34	34	32
33	V	0					0		33
34	V	17	MANAGEMENT FEES	600,458				(600,458)	34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$ 600,458			$ 201,565	$ * (398,893)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE NURSING CENTER # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMIN. - R. HARTMAN	$	NUCARE SERVICES CORP.	100.00%	$ 91,681	$ 91,681	15
16	V	17	ADMIN. - B. CARR		NUCARE SERVICES CORP.	100.00%	19,692	19,692	16
17	V	17	ADMIN. - D. HARTMAN		NUCARE SERVICES CORP.	100.00%	626	626	17
18	V	17	ADMIN. - E. DICKMAN		NUCARE SERVICES CORP.	100.00%	0		18
19	V	27	EMP. BEN. - R. HARTMAN		NUCARE SERVICES CORP.	100.00%	1,943	1,943	19
20	V	27	EMP. BEN. - B. CARR		NUCARE SERVICES CORP.	100.00%	897	897	20
21	V	27	EMP. BEN. - D. HARTMAN		NUCARE SERVICES CORP.	100.00%	53	53	21
22	V	27	EMP. BEN. - E. DICKMAN		NUCARE SERVICES CORP.	100.00%	0		22
23	V	0					0		23
24	V	0					0		24
25	V	0					0		25
26	V	0					0		26
27	V	0					0		27
28	V	0							28
29	V	0							29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 114,892	$ * 114,892	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE NURSING CENTER # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	CAREPATH HEALTH NETWORK	100.00%	$ 27,856	$ 27,856	15
16	V	19	PROFESSIONAL FEES		CAREPATH HEALTH NETWORK	100.00%	673	673	16
17	V	20	FEES, SUBSCRIPTIONS		CAREPATH HEALTH NETWORK	100.00%	1,169	1,169	17
18	V	21	CLERICAL AND GENERAL		CAREPATH HEALTH NETWORK	100.00%	8,305	8,305	18
19	V	24	SEMINARS		CAREPATH HEALTH NETWORK	100.00%	45	45	19
20	V	27	GEN ADMIN.- EMP. BEN.		CAREPATH HEALTH NETWORK	100.00%	4,844	4,844	20
21	V								21
22	V								22
23	V								23
24	V	17	MANAGEMENT FEES	61,619	CAREPATH HEALTH NETWORK	100.00%	0	(61,619)	24
25	V	0					0		25
26	V	0					0		26
27	V	0					0		27
28	V	0					0		28
29	V	0					0		29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$ 61,619			$ 42,892	$ * (18,727)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE NURSING CENTER # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE NURSING CENTER # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE NURSING CENTER # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE NURSING CENTER # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE NURSING CENTER # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE NURSING CENTER # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKS(# 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	DAVID HARTMAN	RELATIVE	ADMINISTRATIVE		SEE ATTACHED	0.6	0.01	ALLOC NUC/	$ 626	17-7	1
2	BARRY CAR	OWNER	ADMINISTRATIV	4.75	SEE ATTACHED	5.1	0.09	ALLOC NUCAR	19,692	17-7	2
3	ROBERT HARTMAN	OWNER	ADMINSTRATIV	60.75	SEE ATTACHED	4.64	0.07	ALLOC NUCAR	91,682	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 112,000		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NUCARE SERVICES CORP.
Street Address: 6677 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 933-2600
Fax Number: (847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. CENSUS DAYS	634,333	8	$ 6,475	$	85,644	$ 874	1
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	634,333	8	10,636	(714)	85,644	1,436	2
3	7	EMPLOYEE BEN. GEN. SERV.	AVAIL. CENSUS DAYS	634,333	8	(156)		85,644	(21)	3
4	10	NURSING ADMIN. COMP.	AVAIL. CENSUS DAYS	634,333	8	7,912	6,671	85,644	1,068	4
5	14	PROGRAM TRANSPORTATION	AVAIL. CENSUS DAYS	634,333	8	14,386		85,644	1,942	5
6	15	HEALTHCARE BENEFITS	AVAIL. CENSUS DAYS	634,333	8	1,462		85,644	197	6
7	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	634,333	8	15,970		85,644	2,156	7
8	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	634,333	8	22,883		85,644	3,090	8
9	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	634,333	8	1,091,620	894,249	85,644	147,384	9
10	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	634,333	8	7,875		85,644	1,063	10
11	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	634,333	8	3,960		85,644	535	11
12	26	INSURANCE	AVAIL. CENSUS DAYS	634,333	8	1,958		85,644	264	12
13	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS	634,333	8	159,629		85,644	21,552	13
14	30	DEPRECIATION	AVAIL. CENSUS DAYS	634,333	8	40,461		85,644	5,463	14
15	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	634,333	8	(18,956)		85,644	(2,559)	15
16	34	BUILDING RENT	AVAIL. CENSUS DAYS	634,333	8	76,619		85,644	10,345	16
17	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	634,333	8	49,932		85,644	6,742	17
18	39	ANCILLARY	AVAIL. CENSUS DAYS	634,333	8	253	208	85,644	34	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,492,919	$ 900,414		$ 201,565	25

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NUCARE SERVICES CORP.
Street Address: 6677 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 933-2600
Fax Number: (847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMIN. - R. HARTMAN	AVG. HOURS WORKED	37	8	720,633	720,000	5	91,681	1
2	17	ADMIN. - B. CARR	AVG. HOURS WORKED	40	8	154,447	151,667	5	19,692	2
3	17	ADMIN. - D. HARTMAN	AVG. HOURS WORKED	12	8	12,200	12,000	1	626	3
4	17	ADMIN. - E. DICKMAN	AVG. HOURS WORKED	35	1	3,500	3,500			4
5	27	EMP. BEN. - R. HARTMAN	AVG. HOURS WORKED	37	8	15,274		5	1,943	5
6	27	EMP. BEN. - B. CARR	AVG. HOURS WORKED	40	8	7,034		5	897	6
7	27	EMP. BEN. - D. HARTMAN	AVG. HOURS WORKED	12	8	1,028		1	53	7
8	27	EMP. BEN. - E. DICKMAN	AVG. HOURS WORKED	35	1	317				8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 914,433	$ 887,167		$ 114,892	25

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPATH HEALTH NETWORK
Street Address: 6633 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (888) 707-6700
Fax Number: (847) 679-2150

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	CARE PATH FEES	608,174	14	$ 274,940	$ 273,771	61,619	$ 27,856	1
2	19	PROFESSIONAL FEES	CARE PATH FEES	608,174	14	6,646		61,619	673	2
3	20	FEES, SUBSCRIPTIONS	CARE PATH FEES	608,174	14	11,535		61,619	1,169	3
4	21	CLERICAL AND GENERAL	CARE PATH FEES	608,174	14	81,974	63,989	61,619	8,305	4
5	24	SEMINARS	CARE PATH FEES	608,174	14	449		61,619	45	5
6	27	GEN ADMIN.- EMP. BEN.	CARE PATH FEES	608,174	14	47,810		61,619	4,844	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 423,354	$ 337,760		$ 42,892	25

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSO # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	LASALLE BANK		X	LINE OF CREDIT	INTEREST. ONLY		AS NEEDED	1,100,000	7/01 ANNUAL		94,178	6
7					PRIME +1				RENEWAL			7
8												8
9	TOTAL Facility Related						$	$ 1,100,000			$ 94,178	9
	B. Non-Facility Related*											
10	Supplemental Schedule										863,169	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 863,169	14
15	TOTALS (line 9+line14)						$	$ 1,100,000			$ 957,347	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	INVESTMENT INCOME						$	$			$ (1,450)	1
2	ALLOC FROM NUCARE										(2,559)	2
3												3
4	ALLOC FROM JACKSON ASSOC										867,178	4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 863,169	21

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE NURSING CE # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	180,045	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	324,059	2
3. Under or (over) accrual (line 2 minus line 1).	$	144,014	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	178,836	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	3,500	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	326,350	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	315,762	8
	1996	325,189	9
	1997	315,547	10
	1998	327,354	11
	1999	325,157	12

2000 TAX ACCRUAL = 325157 x 1.05 = $341,415

LESS: PREPAYMENT OF 3/01 INSTALLMENT OF $ 162,579

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE NURSING CENTER # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 110,407 B. General Construction Type: Exterior BRICK Frame BRICK/CONCRETE Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

MEDICAL CLINIC - COSTS ARE NOT INCLUDED ON PG 3 OR 4

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	89,364	1987	$ 71,619	1
2					2
3	TOTALS	89,364		$ 71,619	3

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE NURSING CEN1# 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	234		1987	1980	$ 3,173,042	$	35	$ 95,250	$ 95,250	$ 1,238,667	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1994	6,544	168	20	327	159	2,011	9
10	Various			1995	57,890	1,484	20	2,896	1,412	16,003	10
11	COMPUTER CABLING			1996	3,014	347	20	151	(196)	617	11
12											12
13	FIRE ALARM PANEL			1996	3,817	98	20	191	93	923	13
14	SUBACUTE REMODEL			1996	83,372	2,138	20	4,169	2,031	19,108	14
15	ROOF REPAIRS			1996	7,900	203	20	395	192	1,712	15
16	WALL LIGHT FIXTURES			1996	2,650	68	20	133	65	576	16
17	SMOKE DETECTORS			1996	2,585	66	20	129	63	527	17
18	PULL STATION & LIGHT			1996	1,064	27	20	53	26	256	18
19	REBUILT PUMP			1996	1,889	48	20	94	46	447	19
20	SMOKE DETECTOR			1996	1,600	185	20	80	(105)	353	20
21	OPEN SITE DRAIN			1996	2,100	54	20	105	51	525	21
22	FIRE ALARM SYSTEM			1996	16,290	418	20	815	397	3,532	22
23	NURSE CALL SYSTEM			1996	3,292	84	20	165	81	715	23
24	MISC PAINTING			1996	696		20			79	24
25	PAGE 12-1 REP TOTALS				2,859	211		116	(95)	242	25
26											26
27											27
28											28
29											29
30	PAGE 12F TOTALS				450,711	1,292		2,777	1,485	127,721	30
31	PAGE 12E TOTALS				106,526	1,991		4,104	2,113	4,104	31
32	PAGE 12D TOTALS				54,922	908		1,854	946	2,292	32
33	PAGE 12C TOTALS				70,218	1,801		3,513	1,712	6,062	33
34	PAGE 12B TOTALS				72,066	1,849		3,604	1,755	12,277	34
35	PAGE 12A TOTALS				73,720	2,099		3,817	1,718	13,145	35
36	TOTAL (lines 4 thru 35)				$ 4,198,767	$ 15,539		$ 124,738	$ 109,199	$ 1,451,894	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE NURSING CEN1# 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	TILES			1997	1,716	44	20	86	42	337	9
10	GARBAGE DISPOSAL			1997	2,156	55	20	108	53	432	10
11	MISC PAINTING			1997	8,035	224	20	437	213	1,347	11
12	GENERATOR BATTERY			1997	967	25	20	48	23	188	12
13	CONDUIT & WIRING			1997	709	18	20	35	17	140	13
14	DRAPERIES/CARPET			1997	4,450	114	20	223	109	669	14
15	PHOTO SMOKE DET			1997	1,906	49	20	95	46	380	15
16	FIRE SYS UPGRADE			1997	1,708	44	20	85	41	326	16
17	DISPOSAL CONTROL			1997	2,258	58	20	113	55	443	17
18	CCTV SYS			1997	2,053	53	20	103	50	318	18
19	FIRE SYS UPGRADE			1997	766	20	20	38	18	146	19
20	DOOR REN & SMOKE DET			1997	4,126	106	20	206	100	755	20
21	DOOR MONITOR			1997	1,582	41	20	79	38	257	21
22	CCTV SYS			1997	1,801	46	20	90	44	278	22
23	WALL LAMPS			1997	2,689	69	20	134	65	503	23
24	EMERGENCY OUTLET			1997	6,838	175	20	342	167	1,197	24
25	DRAPERY			1997	12,472	320	20	624	304	2,132	25
26	SMOKE DET INSTALL			1997	1,473	38	20	74	36	290	26
27	BATHROOM STALLS			1997	1,191	31	20	60	29	195	27
28											28
29	ELIMINATOR INST			1997	1,403	36	20	70	34	257	29
30	PHOTO DETECTORS			1997	2,393	61	20	120	59	410	30
31	TELEPHONE EQUIP			1997	582	73	20	58	(15)	179	31
32	CARBON MON DET			1997	3,435	88	20	172	84	645	32
33	SUMP PUMP			1997	2,193	56	20	110	54	367	33
34	TELEPHONE EQUIP			1997	1,319	165	20	132	(33)	429	34
35	CARPET			1997	3,499	90	20	175	85	525	35
36	TOTAL (lines 4 thru 35)				$ 73,720	$ 2,099		$ 3,817	$ 1,718	$ 13,145	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE NURSING CEN1# 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WINDOWS			1997	815	21	20	41	20	154	9
10	TILES			1997	769	20	20	38	18	149	10
11											11
12											12
13	ELEC.WORK			1997	2,900	74	20	145	71	580	13
14	WET CHEM SYS			1997	2,403	62	20	120	58	480	14
15	CCTV SYSTEM			1996	1,719	44	20	86	42	344	15
16											16
17	DECORATING & REPAIRS			1997	7,728	198	20	386	188	1,512	17
18	ELEC WORK			1997	4,110	105	20	206	101	807	18
19	BASE BD			1997	536	14	20	27	13	106	19
20	CCTV REPAIRS			1997	1,065	27	20	53	26	203	20
21	CCTV SYS REPR			1997	2,301	59	20	115	56	441	21
22	SMOKE DET			1997	1,503	39	20	75	36	281	22
23	TILES			1997	2,730	70	20	137	67	537	23
24	TILES			1997	1,059	27	20	53	26	208	24
25											25
26	CUBICAL CURTAINS			1997	24,660	632	20	1,233	601	4,213	26
27	CARPET			1998	2,873	74	20	144	70	432	27
28	DOOR REPAIRS			1998	966	25	20	48	23	144	28
29	ROOF REPAIR			1998	3,450	88	20	173	85	418	29
30	SPEAKER/CAMERAS			1998	1,905	49	20	95	46	269	30
31	INSULATION/SKYLIGHT			1998	3,425	88	20	171	83	385	31
32	OUTDOOR LAMPS			1998	1,151	30	20	58	28	121	32
33	ALAM SYSTEM			1998	1,492	38	20	75	37	175	33
34	DRAPERIES			1998	802	21	20	40	19	120	34
35	ALARM SYSTEM			1998	1,704	44	20	85	41	198	35
36	TOTAL (lines 4 thru 35)				$ 72,066	$ 1,849		$ 3,604	$ 1,755	$ 12,277	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE NURSING CEN1# 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WALLPAPER			1998	624	16	20	31	15	88	9
10	BOILER REPAIRS			1998	3,436	88	20	172	84	344	10
11	WALLPAPER			1998	933	24	20	47	23	141	11
12	WATER HEATER			1998	11,106	285	20	555	270	1,434	12
13	ALARM SYSTEM			1998	1,248	32	20	62	30	171	13
14	PULLSTATIONS			1999	390	10	20	20	10	28	14
15	CLOSED CIRCUIT TV SY			1999	2,742	70	20	137	67	148	15
16	DOOR RESTRICTORS			1999	1,432	37	20	72	35	90	16
17	PUMP REPAIR			1999	575	15	20	29	14	56	17
18	TILES			1999	1,127	29	20	56	27	107	18
19	REPAIR ELEVATOR CAB			1999	3,014	77	20	151	74	302	19
20	REPAIR EMERGENCY PAN			1999	1,714	44	20	86	42	172	20
21	HOT WATER TANKS			1999	500	13	20	25	12	27	21
22	NURSES CALL SYS			1999	216	6	20	11	5	12	22
23	NEW CHIMES			1999	954	24	20	48	24	92	23
24	LIGHT FIXTURES			1999	559	14	20	28	14	30	24
25	ROOF FLASHING			1999	1,200	31	20	60	29	95	25
26	GENERATOR RPR			1999	6,259	160	20	313	153	443	26
27	GENERATOR			1999	440	11	20	22	11	40	27
28	TANK REPAIRS			1999	1,463	38	20	73	35	97	28
29	WINDOW SCREENS			1999	1,038	27	20	52	25	91	29
30	DRYWALL/PAINT			1999	17,800	456	20	890	434	1,187	30
31	DOOR RESTRICTORS			1999	4,758	122	20	238	116	357	31
32	TILES			1999	659	17	20	33	16	50	32
33	WALLPAPER			1999	732	19	20	37	18	59	33
34	INSTALL DRAIN TILE			1999	4,575	117	20	229	112	344	34
35	BLINDS			1999	724	19	20	36	17	57	35
36	TOTAL (lines 4 thru 35)				$ 70,218	$ 1,801		$ 3,513	$ 1,712	$ 6,062	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE NURSING CEN1# 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	FENCE			1999	2,600	67	20	130	63	163	9
10	WATER CONDITIONER			1999	4,050	104	20	203	99	355	10
11	TIMER/MONITOR			1999	803	21	20	40	19	73	11
12	ALARM KEYPADS			1999	1,071	27	20	54	27	99	12
13	SUBMERSIBLE PUMP			1999	2,325	60	20	116	56	232	13
14	DOOR/FRAME			1999	543	14	20	27	13	32	14
15	SAFETY EDGE			1999	1,600	41	20	80	39	100	15
16	TILES			1999	618	16	20	31	15	44	16
17	MONITOR/TELEPHONE			1999	644	17	20	32	15	53	17
18	CEILING TILES			2000	628	13	20	26	13	26	18
19	ADJUST CONTROL PANEL			2000	526	8	20	17	9	17	19
20	INSTALL ELECTRIC DOO			2000	1,635	12	20	27	15	27	20
21	RAN PHONE LINES			2000	869	6	20	14	8	14	21
22	FIRE DAMPERS FOR VEN			2000	5,350	17	20	45	28	45	22
23	INSTALL CCTV & VCR			2000	1,965	6	20	16	10	16	23
24	LINEN CHUTES DOOR			2000	520	1	20	2	1	2	24
25	CARPETING			2000	2,949	29	20	61	32	61	25
26	FLORESENT LIGHTIN			2000	967	7	20	16	9	16	26
27	CABLEING FOR COMPUTE			2000	686	10	20	20	10	20	27
28	3RD FLR NURSING STAT			2000	11,600	260	20	532	272	532	28
29	LIGHT FIXTURE COVERS			2000	826	1	20	3	2	3	29
30	REPAIR COMPRESSOR			2000	3,730	36	20	78	42	78	30
31	10 MNTHS TANK RNTL &			2000	5,460	99	20	205	106	205	31
32	VENTS			2000	1,284	12	20	27	15	27	32
33	START UP REPLACEMNT			2000	252	4	20	10	6	10	33
34	FURNISH & INSTALL			2000	686	10	20	20	10	20	34
35	FURNISH & INSTALL			2000	735	10	20	22	12	22	35
36	TOTAL (lines 4 thru 35)				$ 54,922	$ 908		$ 1,854	$ 946	$ 2,292	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE NURSING CEN1# 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WROUGHT IRON FENCE			2000	1,065	24	20	49	25	49	9
10	BOILER REPAIRS			2000	7,300	117	20	243	126	243	10
11	FURNISH AND INSTALLS			2000	2,024	41	20	84	43	84	11
12	REKEY DIETARY DEPT			2000	1,387	23	20	46	23	46	12
13	2 MOTOR SYSTEMS			2000	174	3	20	6	3	6	13
14	REPAIR REMOTE WIRING			2000	4,157	67	20	139	72	139	14
15	CEILING TILE			2000	715	1	20	3	2	3	15
16	SAFETY SLIDE RAILS			2000	3,371	54	20	113	59	113	16
17	INSTALL REMOTE MULTI			2000	1,672	30	20	63	33	63	17
18	FAUCET & REPAIR KIT			2000	697	7	20	15	8	15	18
19	FRT - INSTALL ICU			2000	1,700	42	20	85	43	85	19
20	INSTALL NEW COMPRESS			2000	16,764	376	20	768	392	768	20
21	INSTALL 78 OVER BD L			2000	13,820	310	20	633	323	633	21
22	5 DINING GARBAGE CAB			2000	1,250	4	20	11	7	11	22
23	SERVICE PA SYSTEM			2000	1,160	4	20	10	6	10	23
24	INSTALL CONTRACTO			2000	2,970	10	20	25	15	25	24
25	TANK REMOVAL			2000	2,914	72	20	146	74	146	25
26	REPAIR DOOR LOCK REP			2000	610	15	20	31	16	31	26
27	CHILLER PARTS			2000	4,050	82	20	169	87	169	27
28	10 MONTHS TANK RENTL			2000	5,000	91	20	188	97	188	28
29	CEILING TILES			2000	846	17	20	35	18	35	29
30	INSTALL TELEPHON			2000	440	8	20	17	9	17	30
31	INSTALL CCTV MONITOR			2000	3,372	75	20	155	80	155	31
32	ENCLOSE 2 SMOKING LG			2000	26,130	475	20	980	505	980	32
33	FURNISH AND INSTALL			2000	896	16	20	34	18	34	33
34	GENERATOR BATTERY			2000	1,348	25	20	50	25	50	34
35	CEILING TILES			2000	694	2	20	6	4	6	35
36	TOTAL (lines 4 thru 35)				$ 106,526	$ 1,991		$ 4,104	$ 2,113	$ 4,104	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE NURSING CEN1# 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	WALL PAPER & BORDER			2000	1,204	19	20	40	21	40	9
10	REPAIR BALLASTS AN			2000	906	18	20	38	20	38	10
11	3' BRASS OVERBED LIG			2000	5,786	117	20	241	124	241	11
12	INSTALL WINDOW TREAT			2000	75	1	20	2	1	2	12
13	HOOK UPS DIALYSIS MA			2000	24,200	492	20	1,008	516	1,008	13
14	INSTALL VOLTAGE COIL			2000	945	5	20	12	7	12	14
15	INSTALL 1-600 TANK			2000	28,500	640	20	1,306	666	1,306	15
16	PAINTING AND DECORATING			2000	2,601		20	130	130	130	16
17											17
18	IMPROVEMENT			1987	152,253		20			50,487	18
19	IMPROVEMENT			1987	46,719		20			15,575	19
20	ELEVATOR			1988	11,968		20			5,681	20
21	IMPROVEMENT			1988	5,129		20			1,585	21
22	IMPROVEMENT			1989	2,630		20			1,245	22
23	ELEVATOR			1989	16,393		20			7,790	23
24	IMPROVEMENT			1990	33,869		20			14,391	24
25	IMPROVEMENT			1991	10,518		20			3,945	25
26	GARGAGE DISPOSAL			1993	729		20			198	26
27	GARGAGE DISPOSAL			1993	1,003		20			275	27
28	CABLING			1993	811		20			225	28
29	PUBLIC ADDRESS SYSTEM			1993	772		20			214	29
30	LEASEHOLD IMPROVEMENTS			1994	103,700		20			23,333	30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 450,711	$ 1,292		$ 2,777	$ 1,485	$ 127,721	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE NURSING CEN1# 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE NURSING CEN1# 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE NURSING CEN1# 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE NURSING CEN1# 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE NURSING CEN1# 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	234				$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ALLOCATED FROM NUCARE			1997	622	16	20	31	15	100	9
10	ALLOCATED FROM NUCARE			1998	545	14	20	27	13	67	10
11	ALLOCATED FROM NUCARE			1999	764	172	20	38	(134)	55	11
12	ALLOCATED FROM NUCARE			2000	928	9	20	20	11	20	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 2,859	$ 211		$ 116	$ (95)	$ 242	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE NURSING CEN1# 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON S(# 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 918,453	$ 64,942	$ 73,111	$ 8,169		$ 630,226	37
38	Current Year Purchases	133,166	25,739	8,768	(16,971)		8,768	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 1,051,619	$ 90,681	$ 81,879	$ (8,802)		$ 638,994	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	RESIDENT CARE	1982 FORD VAN	1990	$ 2,282	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$ 2,282	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 5,324,287	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 106,220	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 206,617	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 100,397	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 2,090,888	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58	HEAVY DUTY WASHER	$ 6,272	58
59			59
60			60
61		$ 6,272	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

JACKSON CORPORATION d/b/a JACKSON SQUARE NURSING CENTER
0039834
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

LINE 28: PRIOR YEARS

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
JACKSON CORPORATION	361,225	60,784	36,292	(24,492)	110,199
NUCARE SERVICES CORP	26,299	4,158	2,270	(1,888)	14,574
PRIOR JACKSON	530,929		34,549	34,549	505,453
TOTALS	918,453	64,942	73,111	8,169	630,226

LINE 29: CURRENT YEAR

JACKSON CORPORATION	127,581	24,645	8,453	(16,192)	8,453
NUCARE SERVICES CORP	5,585	1,094	315	(779)	315
PRIOR JACKSON					
TOTALS	133,166	25,739	8,768	(16,971)	8,768

LINE 30: FULLY DEPRECIATED

JACKSON CORPORATION					
NUCARE SERVICES CORP					
PRIOR JACKSON					
TOTALS					

TOTALS (Should Tie to Totals on Page 13)

JACKSON CORPORATION	488,806	85,429	44,745	(40,684)	118,652
NUCARE SERVICES CORP	31,884	5,252	2,585	(2,667)	14,889
PRIOR JACKSON	530,929		34,549	34,549	505,453
TOTALS	1,051,619	90,681	81,879	(8,802)	638,994

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE NURSING CENTER # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	120
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER AIDE	120

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	80
IN OTHER FACILITY	
HOURS PER AIDE	80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$ 1,468	$ 432	$	$ 1,900
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)	15,339	4,512		19,851
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$ 16,808	$ 4,943	$	$ 21,751
10	SUM OF line 9, col. 1 and 2 (e)	$ 21,751			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	17
2. From other facilities (f)	
TOTAL TRAINED	22

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE N# 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	ALLOCATED FROM NUCARE				10,345			5
6								6
7	TOTAL				$ 10,345 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
   This amount was calculated by dividing the total amount to be amortized N/A
   by the length of the lease .

9. Option to Buy: ☐ YES ☒ X NO Terms: N/A *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 10,600 Description: ALLOC - NUCARE= $6,742; COPY MACHINE= 3858
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$ 0	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE NURSING C # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 78,512	$		$ 78,512	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			1,625			1,625	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			39,020			39,020	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				138,409		138,409	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**	39-1		11,186		23,274	147,509		170,783	13
14	TOTAL			$ 11,186		$ 142,431	$ 285,918		$ 428,349	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE NURSING CE # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1		
2	Complex Medical Equip	
3	Oxygen	11,841
4	AIR BEDS	16,453
5		
6	ENTERALS	119,215
7		
8		
9		
10		
		147,509

	Outside Therapies (Column 5 - Other)	Amount
1		
2	LAB & X-RAY	23,274
3		
4		
5		
6		
7		
8		
9		
10		
		23,274

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE N # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 8,493	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,700,029		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	109,253		6
7	Other Prepaid Expenses	32,574		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule	466,702		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,317,051	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cos	650,125		15
16	Equipment, at Historical Cost	481,582		16
17	Accumulated Depreciation (book methods)	(316,724)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	67,564		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 882,547	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,199,598	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 509,534	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,991		28
29	Short-Term Notes Payable	1,100,000		29
30	Accrued Salaries Payable	345,457		30
31	Accrued Taxes Payable (excluding real estate taxes)	23,656		31
32	Accrued Real Estate Taxes(Sch.IX-B)	178,836		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	20,100		35
	Other Current Liabilities(specify):			
36	See supplemental schedule	202,747		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,392,321	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,392,321	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,807,277	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,199,598	$ #REF!	48

*(See instructions.)

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE # 0039834 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
Due Renaissance at South Shore	3,178	
Employee advances	7,720	
Exchange	942	
Accrued Management Fees	454,862	
	466,702	

OTHER NON CURRENT ASSETS:		
Construction In Progress	6,272	
Good will	108,168	
Amortization of Goodwill	(46,876)	
	67,564	

OTHER CURRENT LIABILITIES:	Amount	Amount
DUE FROM OTHERS	55,114	
PAYROLL EXCHANGE	478	
DEPOSITS PAYABLE	3,117	
DUE TO CHEVY	26,174	
DUE TO RENAISSANCE HC	8,617	
DUE TO PUBLIC AID	109,247	
	202,747	

OTHER NON CURRENT LIABILITIES:		

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE NURSING # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,414,250	1
2	Restatements (describe):		2
3	**Schedule attached**	(1,627)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,412,623	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	394,654	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 394,654	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,807,277	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	JACKSON CORPORATION d/b/a JA(#	0039834	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		1,412,623
Adjustments:		
		-
		-
		-
PRIOR YEAR INCOME ADJUSTMENT		1,627
Total adjustments		1,627
Balance - Beginning of Year		1,414,250
Equity(Deficit) from Page 17 Col 1		1,807,277
Related Party		
Equity(Deficit)	0	
Income	0	
		-
Combined Equity - End of Year		1,807,277

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQ # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,846,145	1
2	Discounts and Allowances for all Levels	(300,566)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,545,579	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	462,272	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 462,272	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	107,826	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	29,470	20
21	Other Medical Services	96,359	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 233,655	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,450	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,450	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,242,956	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,523,815	31
32	Health Care	2,912,745	32
33	General Administration	1,886,189	33
	B. Capital Expense		
34	Ownership	1,918,056	34
	C. Ancillary Expense		
35	Special Cost Centers	479,031	35
36	Provider Participation Fee	128,466	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,848,302	40
41	**Income before Income Taxes (line 30 minus line 40)****	394,654	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 394,654	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** cash basis **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number **JACKSON CORPORATION d/b/a J # 0039834** **Report Period Beginning:** **01/01/00** **Ending:** **12/31/00**

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE NU # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,046	2,287	$ 71,545	$ 31.28	1
2	Assistant Director of Nursing	4,570	4,912	122,083	24.85	2
3	Registered Nurses	35,485	34,359	629,774	18.33	3
4	Licensed Practical Nurses	37,042	40,023	627,774	15.69	4
5	Nurse Aides & Orderlies	119,539	127,528	991,623	7.78	5
6	Nurse Aide Trainees	3,279	3,309	19,851	6.00	6
7	Licensed Therapist	601	601	11,186	18.61	7
8	Rehab/Therapy Aides	5,343	6,113	83,284	13.62	8
9	Activity Director	2,090	2,227	28,403	12.75	9
10	Activity Assistants	5,903	6,352	45,983	7.24	10
11	Social Service Workers	4,303	5,027	59,160	11.77	11
12	Dietician	2,639	3,314	40,455	12.21	12
13	Food Service Supervisor					13
14	Head Cook	4,739	5,123	37,173	7.26	14
15	Cook Helpers/Assistants	21,755	23,328	150,674	6.46	15
16	Dishwashers					16
17	Maintenance Workers	5,032	5,391	90,096	16.71	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,482	1,623	67,810	41.78	20
21	Assistant Administrator					21
22	Other Administrative	1,482	1,623	27,422	16.90	22
23	Office Manager					23
24	Clerical	13,084	14,566	177,789	12.21	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,051	2,279	20,058	8.80	31
32	Other Health Care(specify)					32
33	Other(specify)	1,300	1,300	39,496	30.38	33
34	TOTAL (lines 1 - 33)	273,765	291,285	$ 3,341,639 *	$ 11.47	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY	$ 9,690	1-3	35
36	Medical Director	MONTHLY	21,600	9-3	36
37	Medical Records Consultant	MONTHLY	4,303	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	MONTHLY	4,094	10-3	39
40	Physical Therapy Consultant	78	3,998	10A-3	40
41	Occupational Therapy Consultant	196	8,785	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	50	2,936	11-3	44
45	Social Service Consultant	39	2,162	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	362	$ 57,567		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	75	$ 3,198	10-3	50
51	Licensed Practical Nurses	171	5,817	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	246	$ 9,015		53

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE NURSING CEN # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
MARKETING SALARIES	1,300	1,300	$ 39,496	$ 30.38
	1,300	1,300	$ 39,496	$ 30.38

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQ # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
WAYNE HANIK	ADMINISTRATOR	0	$ 67,810
	3/28/00-12/31/00		
FARHAT SHARIF	ADMINISTRATIVE		27,422
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 95,232

B. Administrative - Other

Description	Amount
MANAGENENT FEES - NUCARE SERVICE	$ 600,458
CAREPATH HEALTH NETWORK	61,619
TOTAL (agree to Schedule V, line 17, col. 3)	$ 662,077
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
STONE, McGUIRE & BENJAMIN	LEGAL	$ 5,547
SACHNOFF & WEAVER	LEGAL	6,047
SAS ARCHITECTS & PLANNERS	ARCHITECT	142
SCHWARTZ, COOPER, GREENBE	LEGAL	167
SEGAL & SEGAL	LEGAL	6,422
MICHAEL MELBER & ASSOC.	LEGAL	187
FR&R	ACCOUNTING	58,654
PERSONNEL PLANNERS	UNEMPLOYMENT CONSULT	7,199
PURCHASING PLUS	PURCHASING CONSULT	1,200
UHF PURCHASING	PURCHASING CONSULT	35
FIRST REAL ESTATE SERVICES	APPRAISAL	3,500
SEE ATTACHED	COMPUTER SERVICES	17,595
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 106,695

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 39,693
Unemployment Compensation Insurance	49,462
FICA Taxes	254,599
Employee Health Insurance	104,731
Employee Meals	19,830
Illinois Municipal Retirement Fund (IMRF)*	
CHICAGO HEAD TAX	6,828
EMPLOYEE BENEFITS	31,410
UNION PENSION	19,877
TOTAL (agree to Schedule V, line 22, col.8)	$ 526,430

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 154
Advertising: Employee Recruitment	28,148
Health Care Worker Background Check	2,462
(Indicate # of checks performed 330)	
YELLOW PAGE ADVERTISING	1,961
PROMOTIONAL ADVERTISING	25,556
DUES AND SUBSCRIPTIONS	9,268
LICENSE AND FEES	3,139
ALLOC FROM NUCARE	3,090
ALLOC FROM CAREPATH	1,169
Less: Public Relations Expense	( )
Non-allowable advertising	(25,556)
Yellow page advertising	(1,961)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 47,429

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	7,423
ALLLOC FROM NUCARE	1,063
ALLOC FROM CAREPATH	45
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,531

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE I # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number JACKSON CORPORATION d/b/a JACKSON SQUARE NURSING C # 0039834 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $8129**

(3) Did the nursing home make political contributions or payments to a politica action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,965** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? **X** YES ____ NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **128,466**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **19,830** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% of ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw